QUALITY IMPROVEMENT SYSTEM

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted Physicians and other providers in the process of QIS development and performance review.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

A. Approves the overall QIS and the annual report of the QIS.

B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.

C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.

D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

4. Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee designated by, and accountable to the governing body and shall be facilitated by the medical director or a physician designee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network, shall actively participate on the committee.

The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHS quarterly. Contractor shall maintain a process to ensure confidentiality of quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

5. Provider Participation

Contractor shall ensure that subcontracting Physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep subcontracting providers informed of the written QIS, its activities, and outcomes.

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their subcontract, at minimum:

1. Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.

2. Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.

3. Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.

4. Contractor's actions/remedies if subcontractor's obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

1. Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

2. Ensures subcontractor meets standards set forth by the Contractor and DHS.

3. Includes the continuous monitoring, evaluation and approval of the delegated functions.

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within the Contractor's organization.

C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.

E. The role, structure, function of the quality improvement committee.

F. The processes and procedures that will ensure that all medically necessary health care services are available and accessible to all Members regardless of race, color, national origin, gender or disability, and that all services are provided in a culturally and linguistically appropriate manner.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.

H. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

I. Description of the activities designed to assure the provision of case management, coordination and continuity of care services.

8. Quality Improvement Annual Report

Contractor shall develop an annual quality improvement report for submission to DHS by the end of each calendar year. The annual report shall include:

A. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of the External Accountability Set measures; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

B. Copies of all reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

C. An assessment of subcontractor's performance of delegated quality improvement activities.

9. External Quality Review Requirements

At least annually or as designated by DHS, DHS shall arrange for an external quality of care review of the Contractor by an entity qualified to conduct such reviews in accordance with Title 22, CCR, Section 53860 (d) and Title 42, USC, Section

1396a(30)(C). Contractor shall cooperate with and assist the External Quality Review Organization (EQRO) designated by the State in the conduct of this review.

A. External Accountability Set (EAS) Performance Measures

The External Accountability Set (EAS) consists of a set of Health Plan Employer Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA) and DHS developed performance measures selected by DHS for evaluation of health plan performance.

Contractor shall calculate all EAS performance measures separately for each specific Service Area. HEDIS rates are to be calculated by the Contractor and verified by DHS selected EQRO. Rates for DHS developed performance measures will be calculated by the EQRO. Contractor shall report audited results on the EAS performance measures. Contractor shall report EAS performance measurement rates to DHS no later than June 15 of each year or such date as established by the DHS and must be audited by DHS selected EQRO. Contractor shall initiate reporting on EAS performance measures for the reporting cycle following the first year of operation.

Contractor shall develop, implement, and submit Corrective Actions to DHS for approval within 90 days of being notified by DHS that minimum performance levels have not been achieved for any EAS performance measure or if a “Not Reported” has been received.

B. Quality Improvement Projects

Quality Improvement Projects (QIPs) are studies performed by DHS health plan Contractors to improve the quality of services delivered in specifically identified problem areas. Contractor is required to be conducting four (4) QIPs at all times. Specifically, Contractor is required to conduct at least one (1) plan-specific QIP, as well as to participate in up to three (3) additional collaborative QIPs including a statewide Medi-Cal Managed Care collaborative project. As part of the four (4) projects, Contractor is required to conduct or participate in at least one non-clinical QIP. When a QIP has been completed, the Contractor must initiate a new project, always maintaining four active projects. Contractors with multiple Service Areas may select the same QIP topic for all of their Service Areas. However, QIPs that are designed to cover the entirety of a multiple Service Area contract may require proportional sampling or other sampling of all Service Areas as required to evaluate geographic differences. Measurement of improvement must be determined for each contract individually. Contractors are not required to use HEDIS indicator specifications for the projects, but may elect to do so.

Non-statewide collaborative QIPs (small group QIPs) may be regionally based (e.g. Southern California health plans) and interest based (e.g. diabetes management) and must be conducted by a minimum of four (4) DHS health plan Contractors. Each QIP is expected to follow four phases that must be completed within 24 months. The Contractor is required to produce a report, using the NCQA Quality Improvement form, to propose initiation of the study and upon

completion of each phase of a QIP. The Contractor is required to obtain DHS approval of the study design, as well as each phase-end report before proceeding with the next phase of the QIP. The four phases are:

a. Phase I – This phase requires the Contractor to :

i. Select a clinical or non-clinical area of study based upon analysis of the need for and feasibility of the project;
ii. Identify the project's goals and objectives;
iii. Determine what questions and/or hypotheses the project will answer or test;
iv. Determine the performance measures and/or quality indicators to be used to measure baseline outcome rates;
v. Develop the project timeline or workplan; and
vi. Develop the specific project methodology to achieve the study objectives.

b. Phase II – This phase requires the Contractor to:

i. Collect and analyze baseline data; and

c. Phase III – This phase requires the Contractor to:

i. Implement interventions;
ii. Conduct a remeasurement after completion of a period of time following initiation of the interventions. This time period will be agreed upon by DHS and the DHS health plan Contractors.
iii. Analyze re-measurement data and document improvement in one or more of the performance measure rates or determine why implementation of interventions failed to achieve improvement; and
iv. Determine revisions/refinements to the interventions necessary before a second re-measurement of data and performance rates.

d. Phase IV – This phase requires the Contractor to:

i. Conduct a second re-measurement demonstrating continued improvement in performance measure rate(s) or indicators of quality or achievement of improvement for the first time as a result of revisions/refinements to the interventions made as a result of the first re-measurement; and
ii. Design and implement an ongoing process to ensure that the demonstrated improvement can be maintained over time.

C. Consumer Satisfaction Survey

At intervals as determined by DHS, DHS's contracted EQRO will conduct a consumer satisfaction survey. Contractor shall provide appropriate data to the EQRO to facilitate this survey.

10. Site Review

A. General Requirement

Contractor shall conduct site reviews on all Primary Care Provider sites according to the Site Review Policy Letter, MMCD Policy Letter 02-02 and Title 22, CCR, Section 53856.

B. Pre-Operational Site Reviews

The number of site reviews to be completed prior to initiating plan operation in a Service Area shall be based upon the total number of new primary care sites in the provider network. For more than 30 sites in the provider network, a 5% sample size or a minimum of 30 sites, which ever is greater in number, shall be reviewed 6 weeks prior to plan operation. Reviews shall be completed on all remaining sites within six (6) months of Plan operation. For 30 or fewer sites, reviews shall be completed on all sites six (6) weeks prior to Plan operation.

C. Credentialing Site Review

A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's provider network. If a provider is added to Contractor's provider network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing.

D. Corrective Actions

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in MMCD Policy Letter 02-02, the Site Review Policy Letter. Primary Care Provider sites that do not correct cited differences are to be terminated from Contractor network.

E. Data Submission

Contractor shall submit the site review data to DHS by January 31 and July 31 of each year. All data elements defined by DHS shall be included in the data submission report.

F. Continuing Oversight

Contractor shall retain accountability for all site review activities whether carried out by the Contractor, completed by other Medi-Cal Managed Care contractors or delegated to other entities.

11. Disease Surveillance

Contractor shall implement and maintain procedures for reporting any disease or condition to public health authorities as required by State law.

12. Credentialing and Recredentialing

Contractor shall develop, and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

A. Standards

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

B. Delegated Credentialing

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with provision 6, Delegation of Quality Improvement Activities, above.

C. Credentialing Provider Organization Certification

Contractor and their subcontractors (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the National Committee on Quality Assurance (NCQA). Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations.

D. Disciplinary Actions

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.

E. Medi-Cal and Medicare Provider Status

The Contractor will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list, cannot participate in the Contractor's provider network.

F. Health Plan Accreditation

If Contractor has received a rating of "Excellent," Commendable" or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHS requirements for

credentialing and will be exempt from the DHS medical review audit of Credentialing.

Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

G. Credentialing of Other Non-Physician Medical Practitioners

Contractor shall develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists and Physician Assistants have been verified in accordance with State requirements.

13. Medical Records

A. General Requirement

Contractor shall ensure that appropriate Medical Records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4) and 42 USC § 1396a(w), shall be available to health care providers at each Encounter in accordance with Title 28 CCR, Section 1300.67.1(c) and Title 22, CCR, Section 53861 and MMCD Policy Letter 02-02.

B. Medical Records

Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:

1. For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.

2. To ensure that medical records are protected and confidential in accordance with all Federal and State law.

3. For the release of information and obtaining consent for treatment.

4. To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Records

Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22, CCR, Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes:

1. Member identification on each page; personal/biographical data in the record.

2. Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

3. All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

4. The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

5. Allergies and adverse reactions are prominently noted in the record.

6. All informed consent documentation, including the human sterilization consent procedures required by Title 22, CCR, Sections 51305.1 through 51305.6, if applicable.

7. Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.

8. Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

9. For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

10. Health education behavioral assessment and referrals to health education services. For patients 12 years or older, a notation concerning use of cigarettes, alcohol, and substance abuse, health education, or counseling and anticipatory guidance.